DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

ROUTINE DENTAL PLAN SURVEY

FINAL REPORT

DENTAL HEALTH SERVICES

ISSUED TO PLAN: FEBRUARY 3, 2003

DENTAL HEALTH SERVICES
FINAL REPORT OF DENTAL SURVEY
February 3, 2003

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SECTION I. Introduction

The Knox-Keene Health Care Service Plan Act of 1975 ("Act"), Section 1380, requires the Department of Managed Health Care ("Department") to conduct a medical survey of each licensed health care service plan at least once every three (3) years. The medical survey is a comprehensive evaluation of a health plan's compliance with the Act. The health plan systems covered in the medical survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] Generally, the survey encompasses review of the Plan's Organization and Staffing, Quality Assurance Program, Utilization Management, Accessibility of Services, Continuity of Care, and Grievance System. Additionally, the subjects of the survey generally fall into the following categories:

- Procedures for obtaining dental health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures to review and control costs;
- Peer review mechanisms;
- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the Plan in providing dental health care benefits; and
- Overall performance of the Plan in meeting the dental health care needs of enrollees.

This Final Report summarizes the findings of the dental survey of Dental Health Services (DHS or the "Plan") The Plan submitted pre-survey documentary information to the Department on October 1, 2002. The on-site review of the Plan was conducted on October 28, 29 & 30, 2002.

As part of the survey process, the Department's survey team conducted interviews and examined documents at the Plan 's administrative offices in Long Beach, California. The names of the survey team members are listed in Appendix A. The titles of persons who were interviewed at the Plan are listed in Appendix BA. A list of acronyms used in this report is provided as Appendix C.

This Final Report summarizes the findings of the medical survey of the Plan. If the Plan wishes to append its response to the Final Report, please notify the Department before February 13, 2003.

The Preliminary Report of the survey findings was sent to the Plan on November 27, 2002. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report. The Plan submitted its response on January 13, 2003.

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[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as Amended [California Health and Safety Code Section 1340 *et seq*. ("the Act"). References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43 and transferred to the Department of Managed Health Care pursuant to Health and Safety Code section 1341.14 ("the Rules")].

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department.

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it, may do so by visiting the Department's office in Sacramento, California after February 13, 2003. The Department will also prepare a Summary Report of the Final Report that shall be made available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. The Final Report to the public will be placed on the Department's website: www.dmhc.ca.gov.

The Plan may file an addendum to its response anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. If the Department finds the Plan's corrective action plan is insufficient to correct a deficiency, the Department may require further Remedial Actions in this Final Report. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

SECTION II. Overview of Plan's Organization and Health Care Delivery System

The following summary is based on information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire (October 2002).

PLAN ORGANIZATION

Dental Health Services (DHS or the "Plan") is a specialty plan that provides commercial dental care services for its enrollees. The Plan has contracted general and specialty dental providers throughout California. The Plan has no Medicare or Medi-Cal enrollees. Members are encouraged to select a dental provider from a provider directory upon enrollment. Members who have not selected a provider are contacted within 30 days of enrollment by a Member Services Representative to assist in the selection or assignment of a provider.

The following additional background information describes the Plan:

Date Plan Licensed:	March 29, 1978
Type of Plan:	Specialized Dental Plan
File Number:	933-0059
Provider Network (September 2002):	Approximately 1200 General Dentists and 700 Dental Specialists (Orthodontists, Oral Surgeons, Periodontists, Endodontists and Pedodontists)
Plan Enrollment (September 2002):	Approximately 84,000 commercial enrollees.
Service Area (46 Counties)	The Plan provides full coverage in the following seven (7) counties: • Los Angeles • Orange • Riverside • San Bernardino • Santa Clara • San Diego • San Francisco

The Plan provides partial or limited coverage in the following thirty-nine (39) counties:

Alameda	Amador	Butte
Calaveras	Colusa	Contra Costa
El Dorado	Fresno	Imperial
Kern	Kings	Lake
Madera	Maricopa	Marin
Mariposa	Mendocino	Merced
Monterey	Napa	Nevada
Placer	Sacramento	San Benito
San Joaquin	San Luis Obispo	San Mateo
Santa Barbara	Santa Cruz	Shasta
Siskiyou	Solano	Sonoma
Stanislaus	Sutter	Tulare
Ventura	Yolo	Yuba

Geographic Accessibility Standards

Urban Areas (General Dentists)

- Within a 15 mile radius of the enrollee's residence or workplace

Rural Areas (General Dentists)

- Within a 25 mile radius of the enrollee's residence or workplace

Urban & Rural Areas (Specialty Providers)

- Within a 25 mile radius of the enrollee's residence or workplace

One (1) Primary Care Dentist (i.e., contracted or plan operated provider) within 30 minutes or 15 miles of the enrollee's residence or workplace.

Appointment Accessibility Standards

General Dentists

- Urgent/Emergent Appointments: Within 24 hours
- Initial Appointment (Preventive Care): Within 3 weeks
- Routine Appointment: Within 4 weeks
- Hygiene Appointment: Within 6 weeks
- In-Office Waiting Time: 30 Minutes

Specialty Providers

- Urgent/Emergent Appointments: Within 24 Hours
- Initial Consultation: Within 3 Weeks
- On-Going Care: Within 4 Weeks
- In-Office Waiting Times: 30 Minutes

DELIVERY MODEL

Dental Health Services (DHS) offers prepaid dental care services to eligible enrollees. The Plan provides general dental and specialized dental health care services to group and individual enrollees. Enrollees are responsible for copayments based on procedures provided.

DHS also offers a direct reimbursement (indemnity type) and PPO dental plan where DHS will reimburse the enrollee for the cost of covered services at the benefit percentages (e.g., 50%) of the usual and customary rate (UCR) for dentists in the enrollee's area up to the maximum amount per person per contract year. The enrollee is responsible for any associated deductibles and for the balance of charges. Under this arrangement the enrollee may receive care at any dental office and may change dentists at any time.

PROVIDER COMPENSATION METHODS

The Plan's network general dentists receive a monthly capitation payment for each member that has selected the network general dentist's office. The Plan also makes supplemental payments to provide a guaranteed minimum amount for designated procedures, office visit fees per member per visit based on encounter data, and in many cases safety net payments to guarantee a specified dollar per chair hour. Orthodontists are compensated on a discounted fee for service basis. All other specialists are compensated depending on their contracted fee schedule.

ARRANGEMENTS FOR OUT OF SERVICE AREA (OSA), SPECIALTY AND EMERGENCY CARE

Out of Service Area (OSA) benefits are provided for services at non-contracted provider offices and requires pre-authorization. DHS will pay the provider's agreed fee (UCR or discounted) less the member's copayments.

- The enrollee lives within a service area that DHS currently does not have a provider contract within 25 miles from the enrollee's business or residence.

- The enrollee lives outside the service area and does not have a DHS Reimbursement Plan or PPO benefits.

- The enrollee is temporarily out of the service area and needs non-emergent care (i.e., emergency care is covered by standard emergency benefits).

The Plan requires pre-authorization for all specialist services. The Plan provides coverage for emergency services. The Plan does not require prior authorization for emergency services. The Plan provides for in-area dental emergency care within 24 hours and each dental office is required to provide 24-hour emergency communication accessibility. Out-of-area emergency care is defined as palliative dental treatment required by an enrollee when more than 50 miles from any DHS dental facility (maximum benefits amounts and copayments apply). Second dental opinions are a covered benefit (copayment required unless the second opinion is requested by a Plan dentist) and are always approved.

If the enrollee believes that he or she requires medical services in an emergency, the Plan recommends the enrollee seek care immediately by calling the "911" emergency response system or going to the nearest hospital emergency room.

UTILIZATION MANAGEMENT

The Plan requires treatment authorization for specialty care. The Quality Assurance (QA) department has oversight responsibilities for the UM process. DHS does not delegate the treatment authorization process to other entities or providers.

SECTION III. Summary of Deficiencies

➢ Deficiencies from Previous Follow-up Review

During this routine dental survey, the Department reviewed the Plan's compliance efforts to fully correct the three (3) uncorrected deficiencies identified in the previous Follow-Up Report dated October 29, 2001, pursuant to Section 1380(i)(2).

Uncorrected Deficiencies

The following deficiencies were not corrected by the Plan at the time of the Follow-Up Review:

- Quality Assurance Deficiencies 1 & 2
- Accessibility of Services Deficiency 1

Findings: The Plan has successfully corrected Accessibility of Services Deficiency 1. However, Quality of Assurance Deficiencies 1 & 2 remain uncorrected and require additional corrective measures to be implemented. Please refer to Quality Assurance Deficiency 3 below for additional information regarding these two uncorrected deficiencies.

➢ Deficiencies from Routine Dental Survey

The Department's routine dental survey of the Plan found the following deficiencies, which the Plan is required to correct:

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's governing body does not review and approve the QA Program on an annual basis. [Section 1367(g), Rule 1300.70(b)(2)(B) & (C)]

Deficiency 2: The Plan's QA Program fails to monitor whether the provision and utilization of services meet professionally recognized standards of practice. [Section 1370, Rule 1300.70(a)(3), 1300.70(b)(2)(C) and Rule 1300.70(c)]

Deficiency 3: The Plan's QA Program requires changes in its audit methodology to ensure dental care services meet professionally recognized standards. [Section 1370 and Rule 1300.70(b)(1)(A) and (B)] ***(Repeat Deficiency)***

Deficiency 4: The Plan's Quality Improvement Program is inadequate to assure a level of care consistent with professionally recognized standards of care. The Plan requires modifications to its Dental Audit Program to ensure the identification and correction of quality of care issues at the Plan's general and specialty dental offices. [Section 1370, Rule 1300.70(a)(1), Rule 1300.70(b)(1)(A) and (B) and Rule 1300.70(b)(2)(E)]

ACCESSIBILITY OF SERVICES

Deficiency 5: The Plan lacks adequate arrangements with general and specialized dental providers sufficient to ensure accessibility to dental health services throughout the Plan's entire service area. [Section 1367(e)(1) and Rule 1300.67.2(a), (d), and (e)]

Deficiency 6: The Plan does not monitor and track enrollee referrals for dental specialty care services. [Rule 1300.67.1(d) and (e)]

GRIEVANCE SYSTEM

Deficiency 7: The Plan does not send acknowledgement and resolution letters to the complainant on a timely basis. [Rule 1300.68(b)(7)]

Deficiency 8: The Plan's resolution letters fail to include the enrollee's right to appeal the initial grievance determination. [Section 1368(a)(1)]

Deficiency 9: The Plan's grievance letters and complaint form do not contain the required language pursuant to Section 1368.02(b). [Section 1368.02(b)]

Deficiency 10: The Plan's governing body and QA committees do not review tabulated grievance data on a quarterly basis. The Plan's QA Manager does not attend the Service Review Committee meetings on a consistent basis. [Rule 1300.68(b)(3)]

UTILIZATION MANAGEMENT

Deficiency 11: The Plan's denial letters related to benefits coverage fail to include the specific provision in the Evidence of Coverage (EOC) that exclude coverage. [Section 1368(a)(4)]

SECTION IV. Summary of Plan's Efforts to Correct Deficiencies

Upon review of the Plan's response dated January 13, 2003 to the Preliminary Report of November 27, 2002, the Department found that the Plan satisfactorily corrected the following Deficiencies:

- Accessibility of Services: Deficiency 5 (Section 5.4)
- Grievance System: Deficiency 9

The following Deficiencies remain uncorrected:

- Quality Assurance Program: Deficiencies 1, 2, 3 & 4
- Accessibility of Services: Deficiency 5 (Section 5.1, 5.2 & 5.3)
- Grievance System: Deficiencies 6, 7, 8 & 10
- Utilization Management: Deficiency 11

Remedial Actions Required. The Department finds the Plan's corrective action plan is insufficient to correct Deficiency Number 11 as requested and requires further Remedial Actions in this Final Report, as stated below:

The Plan shall submit revised policies, procedures, and template denial letters to ensure denials based on coverage (i.e., non covered benefits) clearly specify the language or section of the EOC that limit or exclude coverage. This Remedial Action shall be submitted to the Department within thirty (30) days of receipt of this Final Report.

Please refer to this specific deficiency for additional information.

SECTION V. Discussion of Deficiencies & Corrective Actions

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's governing body does not review and approve the QA Program on an annual basis. [Section 1367(g) and Rule 1300.70(b)(2)(B) & (C)]

Citation:
Section 1367(g) states, in relevant part, that the Plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees.

Rule 1300.70(b)(2)(B) states, in relevant part, that written documents shall delineate QA authority, function, and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

Rule 1300.70(b)(2)(C) states, in relevant part, that the plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

Department Findings: The Department reviewed the Plan's governing body (Board of Directors) meeting minutes dated June 28, 2001, October 2, 2001, December 27, 2001, March 28, 2002 and June 27, 2002. The Department did not find evidence that the Plan's governing body reviewed and approved the Plan's QA Program on an annual basis. On June 28, 2001, the Plan's governing body noted that the minutes from the Quality Assurance Committee (QAC) held on June 26, 2001 were not available for distribution and would be placed as an agenda item for the next executive committee meeting. The minutes of the next Board of Directors meeting held on October 2, 2002 indicated that the QAC meeting had been postponed to Oct. 10 and consequently the minutes of that meeting were not available for the Board's review at that time and the minutes of that meeting will be circulated for review ASAP. There was no evidence that the Board discussed or formally adopted or approved the 2000-2001 and 2001-2002 Quality Assurance Programs (QAP) at this or subsequent Board of Director's meetings as suggested. The

Board of Directors does not provide adequate oversight into the Plan's QA Program via such infrequent attention as provided in the above referenced Board of Directors meeting minutes.

The Plan has established a Quality Assurance Committee that meets on a quarterly basis to review the components of the Quality Assurance Program. The QAC reports to the governing body (Board of Directors). The voting membership of the QAC consists of the following:

- Director/VP of Health Services
- Quality Assurance Dental Director
- Quality Assurance Coordinator
- Dentist Representatives
- Specialist consultants, when necessary, who provide consultation for their specific specialty

The Department reviewed the Plan's Quality Assurance Committee meeting minutes dated March 27, 2001, June 26, 2001, October 10, 2001, December 11, 2001, March 19, 2002, July 9, 2002 and October 1, 2002. Although the committee meets quarterly as required, the membership of the meeting of July 9, 2002 consisted only of the QA Dental Director, the QA Coordinator and another Dentist. The Plan's policy requires that there must be a minimum of four (4) voting members for a quorum to exist. Due to the lack of voting members at this meeting no adoption or approval of committee business can be formally conducted.

Corrective Action 1: The Plan shall ensure that the governing body meets on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. The Plan shall submit a Corrective Action Plan to ensure that the Plan's governing body reviews and approves the Plan's QA Program on an annual basis. Additionally, the Plan shall submit a Corrective Action Plan to ensure that there are sufficient voting members of the QAC at each meeting to form a quorum in order to formally conduct the business of the committee.

Plan's Response and Compliance Efforts 1:

The Plan's response to the Preliminary Report dated January 13, 2003, stated:

1.1. The Plan's Board has not ignored the QA Program. Each year the VP of Health Services presented the QA Program to the Board and received signed approval pages. If there is any fault, it is in the failure to more completely document the Board's consideration and actions taken respecting the Plan's QA Program. This deficiency is now being addressed.

The Plan's records reflect that the Board of Directors and the QA Committee (QAC) each meet separately each quarter. Unfortunately their schedules sometimes did not synchronize so that committee minutes were not available to the Board at its quarterly meeting. This also occurred in the past respecting the Plan's documented annual QA Program. When these occurred, the appropriate documentation (committee minutes or annual program) was distributed to each Board member.

There are three Board members who are geographically scattered. Only one resides in Southern California where the Plan's office is located. Quarterly Board meetings are normally held by telephone conference call. When QA Committee minutes or annual program documentation becomes available after a current Board meeting, each Board member receives copies and they discuss as necessary by phone. Two Board members confer almost daily, and often two or three times a day on Plan business. The third member confers less often but always when action is required. The Plan records reflect that committee minutes and annual program documentation have regularly been considered and approved, often done outside the formal Board meeting because of the failure to synchronize Quarterly QAC meetings to occur prior to Quarterly Board meetings.

Schedules have been changed to assure the quarterly review of QA programs (see below). The QAC meetings are scheduled four to five weeks prior to the Board meetings. QAC minutes will, in each instance, be available for the next occurring quarterly Board meeting, and annual QA Program documentation will be available at a regular quarterly Board meeting for consideration and approval. And if circumstances prevent this from occurring at regular quarterly Board meetings, more detailed evidence of consideration and action by the Board by special meeting or informal conference will be prepared and maintained in corporate records.

- QA COMITTEE SCHEDULED MEETINGS for 2003
    - February 18, 2003
    - May 13, 2003
    - August 12, 2003
    - November 18, 2003

- BOARD of DIRECTORS SCHEDULED MEETINGS for 2003
    - March 27, 2003
    - June 26, 2003
    - September 25, 2003
    - December 26, 2003

1.2. QA Committee Quorum: The Plan's QA Committee has had successful meetings for many years and in the last four years, with the exception on the meeting on July 9, 2002, has had enough voting members to conduct business. The July meeting was an anomaly. Meetings during this time of year are difficult to coordinate with multiple member commitments. Also, three member dentists verbally confirmed but had last minute personal and emergency conflicts and could not attend. The next meeting had nine members in attendance.

In addition to developing a new schedule that should ensure better attendance, the Plan sends the annual schedule to all attendees, verifies attendance two days prior and commits to schedule all QAC with enough members to form a quorum.

Department's Finding Concerning Plan's Compliance Effort 1:

Not Corrected. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's forty-five day response period. The Plan's proposed implementation of the corrective actions will take longer than forty-five days to be accomplished. The Plan has yet to fully adopt and implement its corrective action plan. Although the Plan's response and proposed efforts to correct this deficiency appear to provide the necessary remedial action, the governing body has yet to demonstrate it consistently meets on a quarterly basis or more frequently if problems have been identified, to oversee their respective QA program responsibilities. The 2003 QA Program was revised and approved by the VP of Health Services on January 6, 2003 and has not yet been reviewed or approved by the Quality Assurance Committee or the Plan's governing body. Additional time is required to correct this deficiency and implement the changes proposed in the 2003 QA Program.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

Deficiency 2: The Plan's QA Program fails to monitor whether the provision and utilization of services meet professionally recognized standards of practice. [Section 1370, Rule 1300.70(a)(3), 1300.70(b)(2)(C) and Rule 1300.70(c)]

Citation:
Section 1370 states that every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

Rule 1300.70(a)(3) states that a plan's QA Program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Rule 1300.70(b)(2)(C) states, in relevant part, the plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

Rule 1300.70(c) states that a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services

and facilities, and costs. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the department.

Department Findings: The Plan's QA Program does not adequately provide for the ongoing review and analysis of utilization of services as part of the responsibilities of the governing body and QAC. The Department's review of the Plan's governing body (Board of Directors) and QAC meeting minutes as described in Deficiency 1 above found no evidence of the review and analysis of utilization or encounter data. The Department did not find evidence of regular aggregate utilization reports being reviewed by the Plan's governing body and QAC for the purposes of assessing the over or under utilization of dental care services to ensure that the care provided meets professionally recognized standards of practice.

The Plan does not currently follow the process established in their UM Program. In regards to the monitoring of provider utilization, the Plan's UM program (Page 10) states, "The utilization information is used for monitoring services, and to compute copayments paid by the enrollee and copayments paid by the Plan. It is used in utilization review to determine overall practice activity and activity by benefit plan. The reports are checked for evidence of appropriate services such as preventive services (prophylaxis, fluoride, sealants, etc.). These reports are also used to check for inappropriate fees such as charging fee-for-service for covered benefits. This is part of DHS' anti-fraud program. The utilization reported by the provider is reviewed for accuracy and it may be compared to patient records for accuracy of reporting and billing."

The Department found no evidence of utilization data being review on a continuous basis to identify possible patterns of under- and over-utilization for each contracted provider. The Plan's UM Program does not indicate which Plan staff or committee is responsible for the continuous review of utilization or encounter data. The Department's review of the Plan's governing body, Service Review Committee, Quality Assurance Management Committee (QAMC), QAC, Peer Review Committee, and Utilization Management Committee (UMC) meeting minutes found no evidence of review of utilization data. The Plan's only UMC meeting minutes dated September 12, 2002 states that the Plan's Manager of Dental Operations is currently working on revising the UM report and will present those revisions at the next meeting.

During Department interviews, the Plan's QA Director stated that the Plan's Manager of Dental Operations is responsible for reviewing utilization data on a continuous basis to identify any trends related to under- and over-utilization. Additionally during Department interviews, the Plan's Manager of Dental Operations indicated that he has recently assumed the role of collecting, reviewing and reporting utilization encounter data and is in the process of creating standardized utilization reports. However, the Department found that, at this time, the Plan's governing body and QAC do not review utilization reports on a regular basis to identify trends of under- and over-utilization and to issue corrective actions on identified problems with affiliated providers.

Corrective Action 2: The Plan shall submit a Corrective Action Plan which demonstrates the Plan will continuously review utilization reports and encounter data to ensure utilization of dental care services meets professionally recognized standards of practice. The Plan's CAP

shall include a revised QA Program and UM Program that provides for the QAC and governing body to continuously review aggregated utilization reports for the identification of trends of under-and over-utilization and emergent patterns and for the implementation of corrective actions when problems are found with affiliated providers.

Plan's Response and Compliance Efforts 2:

The Plan's response to the Preliminary Report states that the Plan has revised the QA and UM Programs to ensure that the QAC and the governing body will continuously review aggregated utilization reports for the identification of trends of under- and over-utilization, emergent problems, and for the implementation of corrective actions when problems are found with contracting providers. The Plan's Response includes copies of the revised QA and UM Programs.

Additionally, the Plan's Response states that the Plan's Quality of Care and Performance Monitoring policy and procedure includes the provision and utilization of services as key elements of service in monitoring the quality of care and performance of affiliated providers. The Plan's Response includes a copy of the Quality of Care and Performance Monitoring policy. This policy also requires that corrective action plans and performance improvement goals be reported to the QAC and Board of Directors on a regular basis.

Furthermore, the Plan's Response states that the Plan's Utilization Control Plan is divided into two phases. The first phase consists of the data collection and evaluation of the Plan's existing database to develop norms against which practices of individual participating providers are compared. The Plan has implemented the Monitoring Provider Utilization policy and procedure, which is included in the Plan's Response to monitor utilization trends. The second phase consists of procedures by which the Plan will communicate with participating providers whose practice falls outside the norms, undertake more specific review of those dentists' practices, adopt corrective measures, and, if necessary, terminate the participating agreements with those dentists.

Phase 1: The Plan's Response states that the Plan currently maintains a database for each participating provider. Submitted dental procedures or services are organized by provider identification number and by American Dental Association (ADA) procedure code. Utilization data for providers with twelve months of submitted procedures and at least fifty enrollees or twenty-five subscribers will be reviewed annually. Data is abstracted and evaluated in increments of 100 or more providers. The Plan's Response includes a copy of the Participating Provider Utilization Monitoring Report, which contains data for the first 100 providers for the quarter ending December 31, 2002.

The Plan's Response also states that the Plan will develop norms of utilization for various procedures. These norms will be derived from the aggregate of submitted data and updated on a regular basis based on additional data (encounter forms or utilization reports) submitted by participating providers. The utilization norms will take the form of "basic procedure ratios." The frequency of a specific procedure for each 100 enrollees will be calculated and a mean

number will be determined (e.g., the number of initial exams per 100 enrollees). The frequency of each abuse-prone procedure will be compared to the frequency of utilization of a related basic procedure and a mean number will be determined. For example, the number of scalings will be related to each 100 adult prophylaxis. The Plan will then identify utilization thresholds above the norms for the purpose of determining which dentists have deviated from the norms by more than a reasonable amount. The Plan will continuously monitor participating providers by comparing individual utilization against the thresholds. The Plan's Response includes a copy of the revised UM Program, which includes basic procedure ratios that have been calculated and are included in the data comparison.

Phase II: The Plan's Response states that in the event the Plan identifies a participating provider who appears to be deviating significantly by one or more dental procedures, the Plan will perform an initial review, which may include direct communication with the provider to determine whether he/she is in fact deviating from the norm or if the utilization rate can be otherwise explained. In the event the Plan believes that the utilization rate of any participating provider does not meet the Plan's standards, the Plan may notify any such participating provider and, if uncorrected or warranted, take the steps necessary to terminate the provider's agreement. Where specific evidence or data comes to the Plan's attention relating to the quality of care rendered by any participating provider, the Plan will make reasonable efforts to assess the quality of care based upon reasonable standards of accepted dental practices.

Finally, the Plan's Response includes the following timeframes for implementation:

Task	Completion Date	Status
Utilization Control Plan: • Phase I – 4th Quarter data report • Phase I – Establish norms and utilization thresholds	 • December 31, 2002 • January 31, 2003	 • Completed • In-progress
Review and Approvals: • QAC • Board of Directors	 • February 28, 2003 • March 28, 2003	
Utilization Control Plan: • Phase I – o Revise as needed o Quarterly UM data report • Phase II – Identify over/under utilization	 • April 11, 2003 • April 18, 2003 • April 25, 2003	

Department's Finding Concerning Plan's Compliance Effort 2:

Not Corrected. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's forty-five day response period. The Plan's proposed implementation of the corrective action will take longer than forty-five days to be accomplished. The Plan has yet to fully adopt and implement its corrective action plan.

The Plan's Response states that the Plan has revised the QA Program to ensure that the QAC and the governing body will continuously review aggregated utilization reports for the identification of trends of under- and over-utilization, emergent problems, and for the implementation of corrective actions when problems are found with contracting providers. However, the Plan's revised QA Program fails to include the review of utilization reports as part of the responsibilities of the QAC.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review. At the time of the Follow-up Review, the Plan shall demonstrate that the Plan's QAC and Board of Directors approved the revised UM Program and procedures. The Department will review the Plan's QA Program to ensure utilization data is consistently reviewed by the QAC. The Plan shall also submit committee minutes, utilization reports, and evidence of identification and correction of over- and under-utilization issues at the time of the Follow-up Review.

Deficiency 3: The Plan's QA Program requires changes in its audit methodology to ensure dental care services meet professionally recognized standards. [Section 1370 and Rule 1300.70(b)(1)(A) and (B)] ***(Repeat Deficiency)***

Citation:
Section 1370, as stated above.

Rule 1300.70(b)(1)(A) states that each plan's quality assurance program shall be designed to ensure that a level of care meets professionally recognized standards of practice is being delivered to all enrollees.

Rule 1300.70(b)(1)(B) states that each plan's quality assurance program shall be designed to ensure that quality of care problems are identified and corrected for all provider entities.

Department Findings: The Department reviewed the Plan's provider and facility Quality Assurance (QA) audit process (2002-2003 Quality Assurance Program, Sections: VIII. Quality Assurance Audits, IX. Audit Scoring & Evaluation, X. Confidentiality and, XI. Specialty Audits) and audit forms for general dental and specialty dental providers.

I. The Plan does not adequately define the frequency or methodology of the provider audit and re-audit process.

A. General Dental Providers

Section VIII. Quality Assurance Audits, of the Plan's 2002-2003 Quality Assurance Program states, "upon contracting, and regularly thereafter, each dental office receives a Quality Assurance (QA) audit. Selection of offices for review is based upon the number of members on the provider's panel and/or grievances from members. Offices with a threshold of 35 members are audited and reaudited on a periodic basis. It is unclear when the general dental office will receive subsequent audits due to the use of the terms "regularly thereafter" and "periodic basis"

and if offices that fall beneath the threshold of 35 members are audited. This is a repeat deficiency from the previous Follow-Up report (Quality Assurance, Deficiency 1) dated October 29, 2001. The Plan has not provided adequate information regarding their mechanism to audit provider offices with less than 35 members to ensure all quality of care problems will be addressed for all enrollees.

B. Specialty Dental Providers

Specialty provider audits (other than Orthodontic offices) "are selected based on volume, complaints and claims deficiencies." It is unclear as to the frequency or under what circumstance or criteria (i.e., volume, complaints and claims deficiencies) triggers specialty provider audits." The Plan has a specific timeframe for auditing of orthodontic providers, "Orthodontic offices are reviewed within 2 years of participation with DHS and the orthodontic office will be reevaluated every two years thereafter unless serious deficiencies are noted not to exceed twenty-four (24) months."

II. The Plan's definitions used in categorizing the various types of deficiencies (i.e., minimal, minor, serious, etc.) require clarification. The timeframe for the provider to respond to the corrective actions taken to resolve the deficiencies found in the facility audit needs to be established and defined.

The Plan indicates that once the audit is complete, the Quality Assurance Dental Director grades the audit and a letter is sent to the office with the results.

- Offices with minimal (1 to 2 minor ones) or no deficiencies, are rated as outstanding and are planned for re-audits every 24 months.

- Offices with minor deficiencies are rated as acceptable and are scheduled for re-audits every 18 months. These offices are informed of the minor deficiencies and are requested to make the necessary corrections and reply in writing when they have completed the corrections.

- An office with multiple minor or some serious deficiencies will be rated as acceptable with corrections (provisional) and will be given 30 to 90 days to complete corrections. A follow-up focused audit is scheduled at the end of the designated time period (within 45-90 days) to insure that the serious deficiencies are corrected. If the serious deficiencies are corrected the office will be considered acceptable and re-audited in 12-18 months. If the serious deficiencies have not been corrected, the office will be closed to new enrollment and given notice that serious issues must be corrected within an additional 30 days or may be terminated from the panel.

- If an office has multiple serious deficiencies or such critical deficiencies that patient care may be compromised, the office is given an unacceptable rating and immediately closed to new enrollment. A follow-up focused audit will be within 30-60 days to insure that the serious/critical deficiencies are corrected. If serious/critical deficiencies are completed, the

office will be considered acceptable and the next re-audit will be in 12 months. If the critical deficiencies are not completed, termination from the panel will occur.

It is unclear as to the Plan's meaning and criteria used in categorizing "minimal (1 or 2 minor ones)", "minor," "multiple minor," "serious," "some serious," "multiple serious," "critical," and "serious/critical" deficiencies. In reference to the offices with "minor deficiencies" that are rated acceptable and scheduled for re-audits in 18 months, it is unclear as to the timeframe the provider is given to respond in writing when they have completed the corrections before follow-up inquiries are made or sanctions considered.

III. The Plan does not adequately define by rank or significance (weight) the various categories found on the general and specialty provider facility and patient/enrollee chart audit forms.

The Plan has respective facility and chart audit forms for specialty and general dental offices. The Department reviewed the Plan's Quality Assurance Evaluation Forms (audit tools) for general and specialist (orthodontist) dental providers. It appears that all categories (e.g., Medical History/Consent: Current Medical History versus Medical History/Consent: Initial Complaint) are treated equally (given the same point values) and are not weighed in regards to importance regarding significance (i.e., no differentiation between the ranking or value of an audit finding regarding the lack of a complete medical history verses a notation of the patients initial complaint). There appears to be no methodology or criteria to differentiate the number of points given for more essential categories versus less significant ones. A point or ranking system should be devised and implemented to identify and to weigh the more significant categories over the lesser ones. This is a repeat deficiency from the previous Follow-Up report (Quality Assurance, Deficiency 2) dated October 29, 2001. The Plan has not provided adequate information regarding their scoring mechanism and methodology.

Corrective Action 3: The Plan shall submit a Corrective Action Plans to include, but not limited to the following to address the Department's findings identified in Sections I, II & III above:

I.A.1. Develop the methodology and implement a process and establish distinct timeframes that identifies when general dental offices will receive their secondary (after initial participation with DHS) and subsequent audits.

I.A.2. Develop the methodology and implement a process and establish distinct timeframes to ensure that all provider's offices will be audited on a routine basis

I.B. Develop the methodology and implement a process to identify the frequency and/or define under what circumstance or criteria trigger specialty provider audits.

II. The Plan's definitions used in categorizing the various types of deficiencies require clarification. Please revise or define the terms "minimal (1 or 2 minor ones)", "minor," "multiple minor," "serious," "some serious," "multiple serious," "critical," and

"serious/critical" deficiencies. Please establish appropriate scoring guidelines and criteria.

In regards to offices with "minor deficiencies" that are rated acceptable and scheduled for re-audits in 18 months, please define the timeframe the provider is given to respond in writing when they have completed the corrective actions before follow-up inquiries are made or sanctions imposed.

III. The Plan shall develop a Corrective Action Plan to ensure dental care services meet professionally recognized standards. The Plan's CAP shall include, but not limited to a revised QA audit methodology system so that audit categories are identified and weighed or scored according to the importance or significance between lesser verses more significant related deficiencies.

Plan's Response and Compliance Efforts 3:

The Plan's response to the Preliminary Report dated January 13, 2003, stated:

3.1 (Section I.A.1.) General Dental Audit Timeframes

This is a repeat deficiency; however, most of the issues and requirements within the category are different. Specifically, the requirement to have a timeframe to audit dental offices, including those with low enrollment, was addressed during the last audit response and a reduction of the audit threshold from 100 members to 35 was accepted. The accepted response at that time included no provision for routinely auditing and re-auditing offices with less than 35 members. The current deficiency ignores the previous solution and now appears to require the Plan to audit all providers regardless of member count.

The Plan does have a methodology regarding the timeframe when general dental offices will receive their secondary audit. However, the Plan failed to fully explain the process in the Quality Assurance Program 2002-2003. The Plan's revised QA Program 2003, effective January 1, 2003, states in detail the methodology of the distinct timeframes when general dental offices will receive their secondary (after initial participation with the Plan) and subsequent audits. In addition, the Plan has revised the program to include routine auditing of offices with 5 to 35 members; offices with less than 5 members are not routinely (audit intervals of 2 or 5 years) audited because there would not be a valid chart sample to audit. In addition to routine audits any provider office may be audited regardless of enrollment based on members, groups or plan staff concerns or complaints regarding any aspect of care. (Ref: the Plan submitted their 2003 QA Program, revised 1/6/03).

For offices with 35 or more members: A first audit is completed after two years of being contracted with a current threshold of 35 members. The second and subsequent audits are determined based on the initial audit rating score. The intervals are:

- *Outstanding rating- 24 month intervals (from date of first audit)*

- *Acceptable rating- 18 to 24 month intervals (from date of first audit)*
- **Acceptable with Corrections rating- 30 day provider response*
- **Unacceptable rating- 30 day provider response*

For offices with 5 to 35 members: A first audit is completed after five years of being contracted with less than 35 members (at the time of the audit). The second and subsequent audits are determined based upon the initial audit rating score. The intervals are:

- *Outstanding rating- 5 year intervals (from date of first audit)*
- *Acceptable rating- 4 to 5 year intervals (from date of first audit)*
- **Acceptable with Corrections rating- 30 day provider response*
- **Unacceptable rating- 30 day provider response*

* Acceptable with corrections and Unacceptable ratings are followed up by either a Provider Representative and/or a certified auditor to verify that all deficiencies have been corrected and/or help the provider correct any deficiencies that need improvement. After the follow up is done, the provider will receive a second rating based on the follow up results.

3.2 (I.A.2. and I.B.) All General and Specialty Audit Timeframes

The Plan audits all general dental offices at least once every five years. Specialty offices with a minimal level of utilization (five or more member claims during the previous year) are audited at least once every five years. The Plan also audits "as needed." Any general or specialty office, regardless of enrollment, may be audited when complaints or concerns regarding quality of care are received from members, groups or plan staff. The Plan's revised QA Program 2003, effective January 1, 2003, states in detail the methodology of the distinct timeframes when general and specialty dental offices will receive quality assurance audits.

The Plan's has an implementation program to insure compliance with the above audit timeframes. General offices with low enrollment and specialty offices with minimal levels of utilization are listed on a provider audit schedule (Ref: the Plan submitted their 2003 Provider Audit Schedule and Specialist Audit Schedule).

3.3 (II.) Definitions

The Plan has revised the QA Program to include definitions relating to the various types of dental quality audits (Ref: the Plan submitted their 2003 QA Program, revised 1/6/03).

3.4 (II.) Scoring Guidelines and Criteria

The Plan's scoring guidelines have been revised to include a numerical score. A percentage score is determined from the total points received divided by the total possible points (Ref: the Plan submitted their 2003 QA Program, revised 1/6/03). The Plan's audit tool has also been revised to incorporate the point system (Ref: the Plan submitted their current Audit

Tool). The scale may be revised as the Plan evaluates future supporting data. The following scale is currently used to determine the audit grade:

85 -100%	*Outstanding*
70 - 84%	*Acceptable*
65 - 69%	*Acceptable with corrections*
< 64%	*Unacceptable*

The evaluation of the charts is in accordance to the following standards:

1. *Established protocols from the California Association of Dental Plans.*
2. *California Dental Association Peer Review Manual, revised May 2000*
3. *Quality Evaluation of Dental Care – Guidelines for the Assessment of Clinical Quality and Professional Performance, Third Edition, 1999*

3.5 (II.) Provider Response Timeframes

The Plan revised the QA Program 2003 as of January 1, 2003 to include the provider response timeframes. The timeframes for both general and specialty are the same. The provider has 30 calendar days from the date of the letter (notifying the provider of the actual audit tool, their audit score and any deficiencies) to return to the Plan a copy of the corrective action form highlighting any deficiencies. The provider returns a written acknowledgement of receiving their audit results and attests that they will comply with the correction of deficiencies by initialing each deficiency and signing the corrective action form. The form must have the doctor's signature and initials on each deficiency. The mailing of the notice and receipt of the returned form is logged and tracked.

3.6 (III.) QA Audit Methodology

The three categories of issues that will automatically place a provider in the "Acceptable with Corrections" rating are related to:

1. Any issue which directly affects the medical status of the patient
2. Any issue which directly affects the quality of care of the patient.
3. Any issue which is a direct breach of the contractual obligations of the provider.

Issues that directly affect the medical status of the patient include:

1. Failure to proper evaluate the medical history and deliver care accordingly.
2. Failure to premedicate when indicated.
3. Failure to obtain a medical clearance for treatment
4. Failure to prescribe or administer drugs or anesthetic appropriately.

Issues that directly affect the quality of care of the patient include:

1. Failure to have sufficient number and quality radiographs to support a comprehensive examination and treatment plan.

2. A pattern of practice that indicates the improper, inadequate or substandard diagnosis and treatment outcome in a category of services: Oral Diagnosis, Preventative Dentistry, Operative Dentistry, Crown and Bridge, Endodontics, Periodontics, Prosthodontics and/or Oral Surgery.

3. Failure to provide a referral to specialists.

The Plan submitted the following documents as exhibits in support of their response:

- 2003 QA Program [Modified (underlined) version representing changes to the 2002 QA Program dated 1/6/03]
- 2003 QA Program [Final copy, revision date and approval by the VP of Health Services 1/6/03)
- Provider and Specialist Audit Schedules for 2003
- Audit Tool (Modified CADP Chart Audit Tool Form, revision date 10/02)

Department's Finding Concerning Plan's Compliance Effort 3:

Not Corrected. 1.A.1. The Plan has modified their 2003 QA Program that establishes a timeframe when general dental offices will receive their secondary (after initial participation with the Plan) and subsequent audits:

- Offices with 35 or more members receive their first audit after two (2) years of being contracted with the Plan.
- Offices with 5 to 35 members receive their first audit after five (5) years of being contracted with the Plan.

However, the Plan has yet to formally approve, adopt and implement the 2003 QA Program.

I.A.2. The Plan states that it routinely audits all general dental offices at least once every five years (see 1.A.1. above) however, the Plan does not routinely audit offices with less than five members because there would not be a valid chart sample to audit. The Plan also states that any general or specialty office, regardless of enrollment, may be audited when complaints or concerns regarding quality of care are received from members, groups or Plan staff (i.e. "as needed audit").

The Plan must develop the methodology and implement a process and establish distinct timeframes to ensure that <u>all</u> providers' offices will be audited on a <u>regular</u> <u>basis</u> (i.e., regardless of enrollment).

I.B. The Plan states that specialty office audits (except Orthodontics) with a minimum level of utilization (five or more claims during the previous year) are audited at least once every five years and all Orthodontic offices are scheduled for review within twenty-four (24) months.

Currently, the Plan routinely audits all Orthodontic specialty offices regardless of enrollment. However, as stated above, the Plan must develop the methodology and implement a process and establish distinct timeframes to ensure that all providers' offices (general and specialty) will be audited on a regular basis (i.e., regardless of enrollment).

II. The Plan appears to have removed the unclear terms used in categorizing the various types of deficiencies (i.e., minimal, minor, multiple minor, serious, some serious, multiple serious, critical and serious/critical) that were used in scoring the general and specialty provider audits. However, the Plan continues to use the following terms for the Orthodontic office audits:

- Zero or minimal infractions are rated as outstanding
- Minor deficiencies are rated as acceptable
- Serious deficiencies are rated as provisional
- Critical deficiencies require correction to achieve an acceptable rating

For clarity and consistency the Plan should utilize similar scoring and grading criteria and terminology. The Orthodontic audit scoring and grading should be similar to that used in the general and specialized provider office audits:

85 -100%	*Outstanding*
70 - 84%	*Acceptable*
65 - 69%	*Acceptable with corrections*
< 64%	*Unacceptable*

The Plan states that it has revised the 2003 QA Program to include the provider response timeframes and that both general and specialty timeframes are the same (i.e., the provider has 30 calendar days from the date of the notification letter from the Plan of their audit score and any deficiencies). The provider is required to return a copy of the corrective action form indicating compliance with the corrective action requested.

Upon review, there appears to be no consistent mechanism in place to address those providers that do not comply with the Plan's notification letter. The proposed 2003 QA Program, Section XIV. E., Post-Audit Action, states, "Providers with a rating of 'Unacceptable' will be advised of their status and a determination made if they wish to work with the Quality Assurance Department in rectifying the deficiencies and continue as a provider. A provider terminated due to an Unacceptable rating in a Quality Assurance Audit is subject to an 805 filing." The Plan's post-audit action process is inadequate and incomplete in that there are no clearly defined or established timeframes or definitive sanctions imposed if the provider chooses not to comply in correcting the deficiencies. The Plan must include these elements in their current QA Program.

III. The Plan's response identified several issues (and provided examples) that would automatically place a provider in the "Acceptable with Corrections" rating category (2003 QA Program, Section XIV.D. Critical issues that would modify grade).

- Any issue which directly affects the medical status of the patient
- Any issue which directly affects the quality of care of the patient
- Any issue which is a breach of the contractual obligation of the provider.

The Plan's response enhances the provider audit process by establishing significant issues and criteria that are consistently used across all providers that automatically produce an audit score of "acceptable with corrections." However, the Plan has yet to formally approve, adopt and implement the 2003 QA Program.

In summary, the Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's forty-five day response period to correct this deficiency as requested. The Plan's proposed implementation of the corrective action will take longer than forty-five days to be accomplished. The Plan has yet to fully adopt and implement its corrective action plan. The 2003 QA Program was revised and approved by the VP of Health Services on January 6, 2003 and has not yet been reviewed or approved by the Quality Assurance Committee or the Plan's governing body. Additional time is required to correct this deficiency and implement the changes proposed in the 2003 QA Program.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

Deficiency 4: The Plan's Quality Improvement Program is inadequate to assure a level of care consistent with professionally recognized standards of care. The Plan requires modifications to its Dental Provider and Patient/Enrollee Chart Audit Program to ensure the identification and correction of quality of care issues at the Plan's general and specialty dental offices. [Section 1370, Rule 1300.70(a)(1), Rule 1300.70(b)(1)(A) and (B) and Rule 1300.70(b)(2)(E)]

Citation:
Section 1370 states, in relevant part, that every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

Rule 1300.70 (a) (1) states, in relevant part, that the QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Rule 1300.70 (b) (1) (A) and (B) states, in relevant part, that each plan's quality assurance program is to be designed to ensure that: (i) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees; (ii) quality of care problems

are identified and corrected for all provider entities.

Rule 1300.70(b)(2)(E) states, in relevant part, that physicians, dentists, optometrists, psychologists or other appropriate licensed professionals participation in QA activities must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

Department Findings: The Plan's audits of its general dental and specialty practice offices failed to detect deficiencies in the quality and continuity of care provided to all enrollees. Therefore, the Plan's quality assurance program does not ensure the consistent identification and correction of quality of care and continuity of care issues at the Plan's general and specialty dental offices. Because the Plan's audit review failed to identify deficiencies, the Plan's audits failed to provide information to the dentist so that deficiencies could be corrected.

The Plan does not follow it own established policies and procedures relative to provider and patient/enrollee chart auditing nor does it ensure professionally recognized standards of care are being consistently provided to all enrollees. Of the charts reviewed by the Department, many had discrepancies between the findings made by the Plan's auditor compared with the Department's assessment of clinical services rendered meeting professionally recognized standards.

The Department reviewed patient/enrollee charts from five general dental practices and one (1) specialist (Orthodontic) dental provider during this survey. These charts were initially reviewed and audited by the Plan.

The following trends or potential systemic issues have been extrapolated from the analysis of the deficiencies found from the chart audits.

1. *Patient Identification*
   a. Patient identification and registration forms were deficient in providing adequate patient information [e.g., missing information included date of birth (particularly with a minor), social security number, chief complaint, physician's name and phone number and emergency contact information]

2. *Informed Consents*
   a. Informed Consent Forms were found to be frequently inaccurate or incomplete in 13 of the 26 charts reviewed (e.g., the tooth number to be extracted was not listed, the specific dental treatment provided was not checked, the consent form was not dated)

3. *Medical History*
   a. Medical history forms were not consistently updated and lacked complete documentation of patient allergies (e.g., lack of current or updated medical history & absence of a notation of the patients allergy to Fen-Phen or latex)

4. *Follow-Up & Continuity of Care*
   a. Inconsistent or lack of documentation regarding needed follow-up care was found in 18 of the 26 charts reviewed [e.g., broken appointments with no rescheduling attempts, serious additional treatment needed but no follow-up notes, serious concerns listed on chart (i.e., abscess, parasthesia, overfill RCT, radiolucent areas at apex, crowns required after RCT) and referral to specialist with no subsequent notation in the chart or progress notes of outcomes.

5. *Radiographs*
   a. Radiographs (X-rays) were inadequate in quality (insufficient quality to identify pathology or compare prior treatment) or quantity to conduct a comprehensive dental exam and support a diagnosis (e.g., no baseline or complete x-ray series on adults were evident in several cases as is customarily done during the patient's first visit). Return visits lacking sufficient X-rays [e.g., generally two (2) or four (4) bitewings and any necessary periapical X-rays are required for a return visit]. Findings frequently found only one (1) bitewing and/or one (1) periapical was taken. In some cases posterior periapical X-rays were warranted in order to show root and surrounding bone. Radiographs were often found undated.

Corrective Action 4: The Plan shall submit a Corrective Action Plan that provides evidence demonstrating it has revised its Quality Assurance Program (QAP), workplan and evaluation and associated Dental Provider and Patient/Enrollee Chart Audit Policies and Procedures to include, but not limited to:

- Develop and implement a mechanism or process to ensure the five (5) recurrent patient chart audit findings outlined above are consistently monitored, reviewed and evaluated in order to correct the potential systemic deficiencies found in the chart audit process.

- Develop and implement additional mechanisms for the training and monitoring of auditors regarding the use of the chart audit instrument with instruction on following stated protocols.

- Develop and implement appropriate interrator reliability monitoring processes or policies and procedures (P&Ps) to ensure that the consistent application of audit criteria and standards are applied by all evaluators and that these standards are measured and consistent with sound clinical principles and standards. Interrator reliability training and monitoring should be routinely conducted to ensure the accuracy of the audit process and results documented and submitted to the appropriate quality management committee for incorporation into the Plan's Quality Assurance Program.

The Plan shall modify its dental audit program and institute mechanisms and systems to improve the collection and quality of patient and provider audit data. The outcome desired is to provide satisfactory data and documentation needed to evaluate and detect deficiencies in the quality of care at the Plan's general and specialty dental offices.

Plan's Response and Compliance Efforts 4:

The Plan's response to the Preliminary Report dated January 13, 2003, stated:

4.1 Dental Chart Reviews

The Plan believes the Department arrived at some incorrect conclusions based on an incomplete comparison of the Plan's audit results to the Department's chart reviews. Four "Citations" (Section 1370 and Rule 1300.70) were referenced. The Plan believes that its' QA Program and staff provide service in accordance with the listed citations.

The Plan's Quality Assurance Program involves our QA Coordinator selecting ten charts that represent a variety of clinical procedures as reflected in the provider's submission of utilization and supplemental payment. Each of these ten charts are evaluated by a CADP Certified Auditor and tabulated with results from the other charts selected. From the tabulated results, a pattern of practice for the provider is identified. The threshold for acceptable in any given area is 70%. Unacceptable scores in critical areas are identified and a customized corrective action plan is formulated for the provider. An unacceptable score in a critical area places the provider in a "Provisional" (Unacceptable if corrections are not completed) rating.

The Plan believes that the Plan audits were at least as comprehensive and detailed as that of the Department's. The Department indicated that the Plan's audits failed to detect deficiencies, failed to provide information to the dentist so that deficiencies could be corrected, and that there were discrepancies between the finding made by the Plan's auditor compared with the Department's assessment of clinical services rendered. The Plan disagrees with the conclusions drawn from the above statements.

The Plan believes its' audit program is very effective in detecting deficiencies and providing corrective action information to, and follow-up with, the provider. The Plan does not dispute the clinical findings by the Department. Although the Plan auditors did not in all cases find the identical deficiencies listed by the Department, most were discovered and the provider was informed of them prior to the Department's audit. There were also many deficiencies that the Plan's auditors found (and notified the provider) that were not noted by the Department's auditor. An overall assessment is that the Department found similar findings for 10 of the patients, the Plan focused on different issues on 5 patients and the Plan was more critical for 10 patients (Ref: the Plan submitted the table: DMHC Chart Variance)

Of the six providers reviewed, the Plan had already assigned, prior to the Department's audit, all six as "Provisional" (unacceptable until corrections are completed), notified the providers of their deficiencies and followed up to ensure improvement and compliance. It appears that the Department auditors failed to take note of this action by the Plan.

A summary of the comparison of the two audits:

Provider #	Patients	Total Items Unacceptable		Plan Assigned Provider Status
		DMHC	PLAN	
1	5	13	30	Provisional*
2	5	11	42	Provisional*
3	6	14	32	Provisional*
4	6	17	40	Provisional*
5	2	4	16	Provisional*
6	1	0	7	Provisional*

* "Unacceptable - until correction of deficiencies are completed" and "Provisional" were replaced in 2002 with the more commonly used "Acceptable with corrections." The Plan considers all terms to be equivalent.

4.2 Audit Instrument Improvements

The Plan believes that the results listed in 4.1 validate the Plan's current audit tool/instrument. However, minor improvements can always be made. The Plan has revised its' audit instrument to match the "universal dental audit tool" approved by the industry (CADP, CDA and ADA) and the Department (Ref: the Plan submitted their current Audit Tool). The Plan's (and we believe the Department's) auditors are already CADP certified and familiar with the instrument.

The five recurrent patient chart audit findings outlined in the Preliminary Report are consistently monitored, reviewed and evaluated using the Plan's existing audit instrument and will continue with the new instrument.

4.3 Auditor Reliability Training

Auditor reliability training and calibration is a critical component of the QA Program. Training of the Plan's quality assurance auditors occurs in three ways: 1) CADP training and certification, 2) annual training and calibration by the Dental Director or other professional (Orthodontists train/calibrate Orthodontists), and 3) ongoing (weekly/monthly) communication and feedback between the Dental Director and the auditors. Interrator reliability training and monitoring meetings by the Dental Director occur annually and is next scheduled in February 10, 2003. Results of the interrator monitoring and training program are presented to the QA Management Committee on an annual basis.

The Plan submitted the following documents as exhibits in support of their response:

- DMHC Chart Variance
- Audit Tool (Modified CADP Chart Audit Tool Form, revision date 10/02)

Department's Finding Concerning Plan's Compliance Effort 4:

Not Corrected. 4.1 The Plan did not develop and implement a mechanism or process to ensure the five recurrent patient chart audit findings identified in the Preliminary Report are consistently monitored, reviewed and evaluated in order to correct the potential systemic deficiencies found in the chart audit process as requested in the CAP. The Plan states "its audit program is very effective in detecting deficiencies and providing corrective action information to, and follow-up with, the provider." However, the Plan is required to monitor, evaluate and report (e.g., via the Plan's QA Program, Workplan and evaluation or other monitoring mechanism) on these five recurring dental chart audit categories found to be a potential systemic problem.

- Patient Identification
- Informed Consents
- Medical History
- Follow-Up & Continuity of Care
- Radiographs

4.2 The Department recognizes that the Plan has revised its audit tool to correspond with an audit instrument entitled the "universal dental audit tool."

4.3 The Plan states that it provides ongoing auditor reliability training and calibration for its quality assurance auditors. Results of the interrator monitoring and training program are presented to the QA Management Committee on an annual basis. Unfortunately, the Plan did not provide any documented evidence (i.e., appropriate sections of the Plan's QA Program, Workplan or evaluation, auditor training/interrator monitoring policies or procedures, auditor training/retraining logs or reports) or results of their auditor reliability training program in support of this activity. The next interrator reliability training and monitoring meeting is scheduled for February 2003.

The Plan's response is inadequate to correct this deficiency as requested. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's forty-five day response period. The 2003 QA Program was revised and approved by the VP of Health Services on January 6, 2003 and has not yet been reviewed or approved by the Quality Assurance Committee or the Plan's governing body. The Plan's proposed implementation of the corrective action will take longer than forty-five days to be accomplished. Additional time is required to correct this deficiency and implement the changes proposed in the 2003 QA Program.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

ACCESSIBILITY OF SERVICES

Deficiency 5: The Plan lacked adequate arrangements with general and specialized dental providers sufficient to ensure accessibility to dental health services throughout the Plan's entire service area. [Section 1367(e)(1) and Rule 1300.67.2(a), (d) & (e)]

Citation:
Section 1367(e)(1) states that all services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

Rule 1300.67.2(a) states that the location of facilities providing primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not to result in unreasonable barriers to accessibility.

Rule 1300.67.2 (d) states, in relevant part, the ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.

Rule 1300.67.2(e) states that a plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.

Department Findings: The Plan does not provide a sufficient number of dental care providers in some of the Plan's service area to ensure reasonable access to all enrollees. The Plan does not consistently follow its own established accessibility monitoring guidelines.

The Plan's response to the pre-survey information and the documentation reviewed during the on-site survey does not adequately explain the geographic boundaries or limitations of its forty-six (46) counties service area. In the description of its service area, the Plan reports that its approved service area consists of seven (7) "key counties" (i.e., Los Angeles, Orange, San Bernardino, San Diego, San Francisco, Riverside and Santa Clara counties). Additionally, the Plan states that it also "services limited/partial areas in many other California counties" [i.e., thirty-nine (39) counties identified in Table 1 below]. It is unclear what territorial boundaries or limitations exist within these thirty-nine (39) counties.

The Plan submitted information indicating their entire service area consists of forty-six (46) counties within California.

The Plan provides "full coverage" in the following seven (7) counties:

Los Angeles
Orange
Riverside
San Bernardino
Santa Clara
San Diego
San Francisco

The Plan also services "limited/partial areas" in the following thirty - nine (39) counties:

Alameda	Amador	Butte
Calaveras	Colusa	Contra Costa
El Dorado	Fresno	Imperial
Kern	Kings	Lake
Madera	Maricopa	Marin
Mariposa	Mendocino	Merced
Monterey	Napa	Nevada
Placer	Sacramento	San Benito
San Joaquin	San Luis Obispo	San Mateo
Santa Barbara	Santa Cruz	Shasta
Siskiyou	Solano	Sonoma
Stanislaus	Sutter	Tulare
Ventura	Yolo	Yuba

The Plan has established the following geographic accessibility standards:

Urban Areas (General Dentists)
- Within a 15 mile radius of the enrollee's residence or workplace

Rural Areas (General Dentists)
- Within a 25 mile radius of the enrollee's residence or workplace

Urban & Rural Areas (Specialty Providers)
- Within a 25 mile radius of the enrollee's residence or workplace

One (1) Primary Care Dentist (i.e., contracted or plan operated provider) within 30 minutes or 15 miles of the enrollee's residence or workplace.

The following table (Table 1) summarizes the information submitted by the Plan's response (Section 1.B.4. – Count of All Office Locations; letter dated September 26, 2002) to the Department's August 27, 2002 request for pre-survey information.

Table 1. Demographic and Provider Network Information (General & Specialized Dental Providers)

County	General	Oral Surgeons	Endodontists	Pedodontists	Orthodontists	Total
Alameda	3	1	2	1	3	10
Contra Costa	3	2	0	1	1	7
El Dorado	0	0	0	0	2	2
Fresno	2	0	0	0	3	5
Kern	3	1	0	1	1	6
Los Angeles	226	71	46	30	91	464
Marin	3	0	0	0	1	4
Orange	78	23	10	7	22	140
Placer	0	1	0	0	1	2
Riverside	44	15	3	4	29	95
Sacramento	3	1	0	0	2	6
San Bernardino	51	20	4	3	19	97
San Diego	52	8	6	2	17	85
San Francisco	4	1	0	0	3	8
San Joaquin	2	0	0	1	1	4
San Luis Obispo	2	0	0	0	0	2
San Mateo	2	0	0	0	2	4
Santa Barbara	6	1	0	1	2	10
Santa Clara	13	4	3	1	7	28
Santa Cruz	0	0	0	0	3	3
Shasta	0	0	0	0	1	1
Solano	1	0	0	0	1	2
Sonoma	1	0	0	0	3	4
Stanislaus	3	1	1	0	2	7
Ventura	9	2	2	1	6	20
Total	511	152	77	53	223	1016

In addition to the above geographical accessibility standards the Plan has established the following key county standards (i.e., a "key county" is defined as a county with greater than 1000 enrollees). The Plan's key county geographical access standard is stated as follows:

- 95% of enrollees shall have access within 15 miles for general dentists
- 85% of enrollees shall have access within 15 miles for orthodontists
- 75% of enrollees shall have access within 15 miles for other specialty dentists (Oral Surgeons, Endodontists, Pedodontists & Periodontists).

The following areas of the Plan's key county network (September 2002):

The following Table (Table 2) provides a summary of selected areas of the Plan's "Key County" service area that fall below the Plan's accessibility guidelines. These service areas lack sufficient numbers of dental providers to ensure dental health care services are provided to all enrollees within reasonable proximity.

Table 2: Key County Geographical Accessibility Status (September 2002)

County	No. of Enrollees	General Dentists (Standard = 95%)	Orthodontists (Standard = 85%)	Oral Surgeons (Standard = 75%)	Periodontists (Standard = 75%)	Pedodontists (Standard = 75%)	Endodontists (Standard = 75%)
San Bernardino	4,876	-	77%	-	-	74%	65%
San Diego	4,797	-	-	74%	-	67%	-
Imperial	2,116	89%	58%	58%	0%	58%	0%
Riverside	1,678	-	-	-	-	67%	72%

Corrective Action 5: The Plan shall submit a Corrective Action Plan that demonstrates that the Plan has arrangements for general and specialized dental health care services in the areas noted in the Department's survey where the Plan lacked sufficient arrangements. The CAP shall include, but not limited to the following:

5.1. The Plan shall clarify and define the Plan's service area and the exact geographic areas served within the thirty-nine (39) counties service area.

5.2. The Plan shall clarify and define "key counties" and "limited/partial service areas" and associated accessibility restrictions and limitations

5.3. The Plan shall submit evidence that demonstrates the Plan provides adequate arrangements with providers within this thirty-nine (39) counties service area contingent upon its established "limited/partial service area" accessibility monitoring guidelines.

In reference to the lack of general or specialized dentists for the seven (7) "key counties" with limited providers, or in circumstances where the only available providers are unwilling to contract with the Plan, the Plan shall respond as follows:

5.4. If the Plan relies upon arrangements in adjacent areas, the Plan shall submit a description of the specific arrangements the Plan has in place and demonstrate these afford reasonable access to services. The Plan shall also alternatively submit evidence that the Plan has attempted, but has been unable, to obtain contracts with providers in these locations and that the Plan commits to pay fee-for-service in these counties.

- The Plan shall submit a description of the timeframe indicating when this coverage was achieved.

- The Plan may choose to file an undertaking that the Plan shall file a material modification to delete any such county from the Plan's approved service area.

The Plan's response shall be sufficiently detailed to provide evidence that it has adequate arrangements with general and specialized dental providers sufficient to ensure accessibility to dental services throughout the Plan's entire service area as measured by its own monitoring guidelines.

Plan's Response and Compliance Efforts 5:

The Plan's response to the Preliminary Report dated January 13, 2003, stated:

5.1. Redefinition of Service Areas

The Plan has redefined its' 'primary service areas' or 'key counties' as counties with over 1,500 subscribers. Key counties continue to include the following 6 counties: Los Angeles, San Bernardino, San Diego, Orange, Imperial and Riverside Counties. Counties with less than 1,500 subscribes are considered 'secondary service areas' (Ref: Description of Plan's Service Area and Provider Availability)

5.2. Geographic Accessibility Standards

The Plan's established geographic accessibility standards are as follows:

General Dentist
- Urban Areas: Access to 1 provider within a 15 mile radius of the member's residence or workplace; and
- Rural Areas: Access to 1 provider within a 25 mile radius of the member's residence or workplace.

Specialty Providers

- Urban & Rural areas: Access to 1 specialist within a 25 mile radius of member's residence or workplace

Please note: The pre-survey data provided to the DMHC regarding proximity in miles to a general dentist in rural areas and specialists was in error and based on access to 1 provider in a 15 mile versus 25 mile radius (Ref: Managed Care Accessibility Analysis). The percent of members with access to one provider or specialist for key counties is *clarified* below.

- 95% of subscribers shall have access to within 15 miles for general dentists
- 85% of subscribers will have access to within 25 miles for orthodontists
- 75% of subscribers shall have access to within 25 miles for other specialty dentists, to include: oral surgeons, endodontists, pedodontists and periodontists.

5.3 Access in Primary Service Areas

Application of geographic accessibility standards to the 6 redefined primary service areas or key counties is provided (Ref: Geographic Access To Care Standards for Key Service Areas). Based upon this data, the Plan has developed and implemented the following corrective action plan to recruit, contract and or make the necessary arrangements with providers in the areas indicated to ensure that dental health services are provided to all enrollees within reasonable access.

Provider Recruitment Plan in Primary Service Areas

San Bernardino County (urban and rural service areas)

- To recruit 1 or more orthodontists to meet access standards by June 30, 2003
- To recruit 1 or more endodontists to meet the access standards by June 30, 2003

Imperial County (remote rural service area, approximately 2 hours drive to the adjacent service area of San Diego)

- To recruit or make arrangements to provide periodontal services to members within access to care standards and within reasonable proximity by June 30, 2003
- To recruit or make arrangements to provide endodontic services to members within access to care standards and within reasonable proximity by June 30, 2003.

In the event the Plan is unsuccessful in recruitment of additional specialists in the areas and time frames specified above, the Plan will make arrangements for services to be provided by contracted providers in adjacent areas or continue to provide needed specialty care with local providers on a fee-for service basis. Arrangements and payment for services are made in accordance with established Out of Services Area (OSA) policy and procedure [Ref: Out of Service Area (OSA) Benefits Policy and Procedures].

5.4. Access in Secondary Service Areas

Current access to general and specialty care providers in secondary service areas is presented in Table 2 - Geographic Access for Secondary Service Areas. Our secondary service areas consist of 42 counties: 6 counties, Calaveras, Colusa, Maricopa, Siskiyou, Yuba and Yuma, currently have no subscribers. The remaining 36 counties (listed alphabetically in Table 2) have from 1 to 297 subscribers. Five counties: Alameda, Kern, San Francisco, Santa Barbara and Ventura, have more than 100 subscribers and are able to support a contracted provider. For these 5 counties, we have established a plan to recruit general and specialty care providers. The remaining 31 counties have a total of 435 subscribers or an average of 14 subscribers per county. For counties with less than 100 subscribers and unable to support a contracted provider, we continue to provide needed general and specialty care via local providers on a fee-for-services basis.

Provider Recruitment Plan in Secondary Service Areas with 100 or more Subscribers

Alameda County: Meets access standards for general and specialty care providers

Kern County:
- Recruit additional general provider(s) to meet access standard by June 30, 2003
- Recruit 1 additional orthodontist to meet access standard by June 30, 2003
- Recruit additional oral surgeon(s), periodontist(s), pedodontist(s) and endodontist(s) in sufficient numbers to meet access standard by June 30, 2003.

San Francisco County:
- Recruit additional periodontist(s) to meet access standard by June 30, 2003.

Santa Barbara County:
- Recruit additional pedodontist(s) and endodontist(s) to meet access standard by June 30, 2003.

Ventura County: Meets access standards for general and specialty care providers

Evidence of Reasonable Access to Care in Secondary Service Areas

Evidence that the Plan provides reasonable access to care for subscribers in secondary service areas is demonstrated by paid claims for non-contracted and contracted general and specialty dental care (Ref: Out of Area Claims Paid By Specialty and County 2002, For Contracted and Non-Contracted Providers).

The Plan submitted the following documents as exhibits in support of their response:

- Description of Plan's Service Area and Provider Availability
- Managed Care Accessibility Analysis (December 16, 2002)

- Out of Service Area (OSA) Benefits Policy and Procedure
- List of Contracted and Non-Contracted Providers
- Provider Recruitment Plan (Table)

Department's Finding Concerning Plan's Compliance Effort 5:

Not Corrected. **5.1 & 5.2** The Plan has redefined its 'primary service areas' or 'key counties' as counties with over 1,500 subscribers. Key counties have been revised to include the following 6 counties: Los Angeles, San Bernardino, San Diego, Orange, Imperial and Riverside Counties. Counties with less than 1,500 subscribes are considered 'secondary service areas' (Ref: Description of Plan's Service Area and Provider Availability). Unfortunately, the revised definitions of 'key counties' as stated by the Plan in their narrative differ from that of their exhibit (Description of Plan's Service Area and Provider Availability) and remain unclear. The submitted document, Description of Plan's Service Area and Provider Availability, indicates the Plan's approved service area consists of all of Los Angeles County, Orange, San Bernardino, San Diego, San Francisco and Riverside Counties, and portions of Alameda, Fresno, Contra Costa, and Santa Clara Counties. This information is inconsistent and does not correspond with the revised list of 'key counties' (Los Angeles, San Bernardino, San Diego, Orange, Imperial and Riverside Counties).

Additionally, the Plan did not indicate what geographic or territorial boundaries or limitations that exist within the remaining counties are served by the Plan. It remains unclear what is meant by "services limited/partial" areas in each of the non 'key counties.' Information is needed to identify what geographic areas are served by the Plan (i.e., cities, zip codes, etc.) within each of these non 'key counties.' Should the Plan wish to redefine or revise its approved service area and methodology for calculating enrollee to provider ratios an amendment or material modification as applicable should be filed pursuant to CCR Title 28 1300.51 (et. seq.) with the Department.

The Plan advised that the pre-survey data provided to the DMHC regarding proximity in miles to a general dentist in rural areas and specialists was in error and based on access to 1 provider in a 15 mile versus 25 mile radius. As noted above, should the Plan wish to revise its approved rural provider accessibility standards an amendment or material modification as applicable should be filed with the Department.

5.3. Conditional upon the revised rural provider geographic access criteria of 1 provider within a 25 mile radius the Plan has provided information that it has sufficient general dental providers in all 6 of its redefined 'key counties'. The Plan has indicated that specialized dental recruiting efforts are ongoing for the areas of these 'key counties' that are below the Plan's established accessibility threshold for specialized dentists (i.e., San Bernardino and Imperial Counties). The estimated time these specialized dentists will be added to the Plan's provider network is June 30, 2003. In the event the Plan is unsuccessful in recruitment of additional specialists in these areas the Plan will make arrangements for services to be provided by contracted providers in adjacent areas or continue to provide needed specialty care with local providers on an Out of Service Area or fee-for service basis. As noted above, should the Plan

wish to revise its approved rural provider accessibility standards an amendment or material modification as applicable should be filed with the Department.

In summary, the Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's forty-five day response period. The Plan's proposed implementation of the corrective action will take longer than forty-five days to be accomplished. Additional time is required to correct this deficiency and implement the changes requested by the CAP. Several of the corrective actions are dependent on the Plan's revising its accessibility standards. As noted above, should the Plan wish to revise its approved provider accessibility standards an amendment or material modification as applicable should be filed pursuant to CCR Title 28 1300.51 (et. seq.) with the Department.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

Corrected. 5.4. The Plan has also stated in regards to their secondary service areas (non 'key counties') the Plan will make arrangements for general and specialized dental services to be provided by local non-contracted providers or contracted providers in adjacent areas on a Out of Service Area or fee-for service basis. The Department found that the Plan's compliance efforts adequately address this deficiency by the time of the forty-five day response.

Deficiency 6: The Plan does not monitor and track enrollee referrals for dental specialty services. [Rule 1300.67.1(d) and (e)]

Citation:
Rule 1300.67.1(d) states that within each area of a plan, basic health care services shall be provided in a manner, which provides continuity of care, including the maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees.

Rule 1300.67.1(e) states that within each area of a plan, basic health care services shall be provided in a manner, which provides continuity of care, including an adequate system of documentation of referrals of physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

Department Findings: The Department found that the Plan does not monitor or track specialty referrals. There is no evidence that the Plan has a mechanism to determine if specialty referrals have been completed as requested by the referring general dentist.

The Plan's Utilization Management Specialty Care Prior-Authorization policy states, "when a member needs to see a specialist, the general provider is required to obtain preauthorization from DHS. If the patient is in pain, the dental office may contact DHS by phone for an immediate emergency referrals. Referrals for non-emergencies are sent in writing with supporting

documentation (x-rays, pocket charting, etc.) when necessary. Dental Health Services will process the preauthorization, assign a specialist and send the preauthorization back to the general provider. The general provider will contact the member to provide the referral. The guidelines for each type of specialty are listed in the provider manual." Page C1 of the Provider Manual indicates that the dental office initiates the referral process by sending a completed *Specialist Referral Form* to DHS. The time for processing of this form (non-emergency referrals) will take between two and three weeks to be processed from the time the form is sent until it is returned. This form appears in the Plan's pre-survey information dated September 26, 2002 (Provider Manual, Page C4) and has provisions for the treatment requested and the date the referral is made by the referring general dentist, the individual and the date of the Plan's authorization, denial, or for consultation only, the date and signature of the specialist (after completion of services). The form appears to contain the necessary data for the Plan to monitor and evaluate specialty referrals but there was no evidence found that documents or tracks the numbers of enrollees referred over a designated period of time, to which provider and dental specialty and if the requested specialty referral services were actually completed. There appears to be no follow-up if the enrollee does not seek specialty care. The Plan does not report on specialty referrals and due to the length of time required by the Plan to authorize specialty care the enrollee may not follow-up with the referral and seek treatment in the event it is authorized. There appears to be no policy or procedure on the part of the referring general dentist or the Plan to encourage or ensure the enrollee receives the needed specialty dental services.

Additionally, the Department's review of the Plan's Board of Directors and QAC meeting minutes for 2001 and year-to-date 2002 found no evidence of review and analysis of specialty referrals to ensure specialty care services are provided on a timely basis. The Plan does not have an adequate system to document specialty referrals or monitor follow-up care.

Corrective Action 6: The Plan shall submit a Corrective Action Plan to ensure the type and number of specialty referral services are monitored and tracked for all affiliated provider offices. The Plan's corrective action shall include a policy, procedure or process for affiliated provider offices to submit information on specialty referrals to the Plan on a routine basis. The Plan's CAP shall also include which Plan committee(s) will be responsible for the review and analysis of specialty referrals to ensure specialty care services are received timely. Finally, the Plan shall submit a mechanism to identify, correct, and follow-up on identified deficiencies for enrollees not receiving specialty care services on a timely basis.

Plan's Response and Compliance Efforts 6:

The Plan's response to the Preliminary Report dated January 13, 2003, stated:

6.1. Reports and Monitoring

> The Plan has always monitored and tracked specialty utilization, and received information on specialty referrals from referring dentists. However, it did not track specialty referrals in a manner that reported numbers of referrals to which provider by

dental specialty or non-completion by the enrollee of the referral. This has now been resolved.

Reports are now generated that reflect activity (number of claims per month) by each specialty and by each specialty office (Ref: List of Specialty Providers). Additional reports list activity (number of claims per month) for each specialty by referring dental office (Ref: Specialty Referral Claims Analysis Report). These reports will be monitored, reviewed and analyzed on a quarterly basis by the Provider Service Manager and the QA Management Committee to ensure access to and appropriate utilization of specialty services. Summary reports are presented to the QA Committee. The reports are included in the overall assessment of provider performance and the Quality of Care and Performance Monitoring program (Ref: Quality of Care and Performance Monitoring Policy and Procedure). The Plan's policy and procedures for monitoring specialty referrals is attached (Ref: Monitoring Provider Utilization).

6.2. Specialty Referral Follow-up Letters

The Plan now identifies and contacts enrollees who have not received specialty care services on a timely basis. Enrollees who have not received approved/requested specialty care are listed each month on a new report. The report lists all specialty preauthorizations that have not had follow-up activity or claims submitted for payment (Ref: Expired Specialty Referral Pre-Authorizations). Custom letters are sent to each enrollee asking them to schedule an appointment with their specialist or contact the Plan for assistance (Ref: Specialist Appointment Letters). The Provider Service Manager reviews referral activity reports on a quarterly basis (Ref: Monitoring Provider Utilization).

The Plan submitted the following documents as exhibits in support of their response:

- List of Specialty Providers
- Specialty Referral Claims Analysis Report – By Referring Provider (1/1/02 – 12/31/02)
- Quality of Care and Performance Monitoring Policy and Procedure
- Monitoring Provider Utilization
- Expired Specialty Referral Pre-Authorizations
- Specialist Appointment Letters

Department's Finding Concerning Plan's Compliance Effort 6:

Not Corrected. The Department found that the Plan's compliance efforts do not adequately address this deficiency by the time of the forty-five day response. Additional time is required to correct this deficiency. The Plan has provided evidence that it is developing a mechanism to monitor, track and follow-up on enrollee referrals for dental specialty services. However, the Plan's Response fails to include evidence that the Plan's governing body and appropriate Plan committees have approved the revised QA and UM Programs and fully implemented the associated policies, procedures and processes.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review. At the time of the Follow-Up Review the Plan shall demonstrate if the revised changes to the 2003 QA and UM Programs pertaining to specialty referrals have been approved and adopted by the QA Committee and governing body and been fully implemented.

GRIEVANCE SYSTEM

Deficiency 7: The Plan does not send acknowledgement and resolution letters to the complainant on a timely basis. [Rule 1300.68(b)(7)]

Citation:
Rule 1300.68(b)(7) states that a grievance system shall provide (1) for the acknowledgement of the receipt of a complaint and notice to the complainant of who may be contacted with respect to the complaint within five (5) days, and (2) for notice and a written statement to the complainant of the disposition or pending status of the complaint within 30 days of the plan's receipt of the complaint. Where the plan is unable to distinguish between complaints and inquiries, they shall be considered complaints.

Department Findings: Page 1 of the Plan's Grievance Process and System policy and procedure states:

> *"Complaints may be made in writing or over the telephone. Within three days of receiving a grievance, Dental Health Services acknowledges receipt of the complaint with a letter to the member. This letter includes a clear and concise explanation of the reasons for the plan's response within 30 days. DHS resolves all grievances within thirty calendar days of plan receipt of the grievance. The enrollee's dental condition is considered when determining the response time. If the plan cannot resolve the grievance within 30 days, then the plan sends written notification to the member of the pending status of the complaint."*

The Department reviewed a total of twenty-five (25) enrollee grievances received by the Plan from January 2001 through September 2002. The Department found the following:

- Sixteen (16) grievance files do not include evidence that an acknowledgement letter was sent to the enrollee or complainant,

- Two (2) grievance files contain acknowledgement letters that were sent to the enrollee after five calendar days of receipt of the complaint,

- Thirteen (13) grievance files fail to contain evidence that the resolution letter was sent to the enrollee, and

- Six (6) grievance files include resolution letters that were sent to the enrollee after thirty days of receipt of the complaint.

During Department interviews, the Plan's Professional Services Coordinator stated that those complaint files that do not have acknowledgement and resolution letters are considered inquiries, not grievances. However, the Department's review of the Plan's grievance log found of those sixteen complaint files that do not contain acknowledgement letters, eleven (11) complaints are classified as grievances and five complaints are classified as inquiries. In addition, for those thirteen grievance files that fail to include a resolution letter, ten (10) complaints are classified as grievances and three (3) are classified as inquiries by the Plan.

Corrective Action 7: The Plan shall submit a Corrective Action Plan to ensure that the Plan sends acknowledgement letters within five (5) calendar days and resolution letters within thirty (30) calendar days of receipt of the complaint. The Plan's CAP shall include a mechanism to internally monitor the Plan's compliance to Rule 1300.68(b)(7) on a routine basis to ensure notification letters are sent to the complainant on a timely basis.

Plan's Response and Compliance Efforts 7:

The Plan's response to the Preliminary Report dated January 13, 2003 states that the Plan has taken steps as of January 1, 2003 to ensure acknowledgement letters are sent within five calendar days and resolution letters sent within thirty calendar days of receipt of the complaint. Grievance procedures underscore the importance of meeting the above response times, procedures are implemented, and staff are trained. The Plan also revised its Service Issue Log, which is included in the Plan's Response, to include the dates the acknowledgement and resolution letters are sent to enrollees.

The Plan's Response further states that monitoring and review of the Plan's compliance to ensure acknowledgement and resolution letters are sent timely has been increased significantly. The Plan implemented appropriate documentation (committee minutes or summary) of frequent reviews, including a standing agenda item to review the Service Issue Log during each Service Review Committee meeting. The committee reviews compliance and, when necessary, directs the Plan's Grievance Coordinator or other staff to ensure the timely mailing of letters. Since this committee meets once or twice a week and one or two QAMC members are in attendance, the letter activity is now closely monitored and management attention is available and ensured.

Department's Finding Concerning Plan's Compliance Effort 7:

Not Corrected. The Department found that the Plan's compliance efforts do not adequately address this deficiency by the time of the forty-five day response. The Plan requires additional time to ensure acknowledgement and resolution letters are sent to complainants on a timely basis. The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review.

Deficiency 8: The Plan's resolution letters fail to include the enrollee's right to appeal the initial grievance determination. [Section 1368(a)(1)]

Citation:
Section 1368(a)(1) states that every plan shall establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Department Findings: Page 4 of the Plan's Grievance Process and System policy and procedure, states:

> *"If the member or provider is not satisfied with the decision reached by the Service Review Panel, the member or provider may request appellate review. The case will then be presented to the Peer Review Committee which will meet, on an ad hoc basis if necessary, to resolve the issue within thirty days following receipt of the member's initial grievance."*

The Plan's Evidence of Coverage (EOC) states:

> *"Dental Health Services makes every effort to resolve grievances within 30 days of notification. Grievances involving emergency care are addressed immediately and responded to in writing within three days. Should you be unhappy with the decision, you may request a review by notifying Dental Health Services in writing. Appeals may include review by the Peer Review Committee."*

Page 11 of the Plan's QA Program for 2002-2003 states:

> *"If the grievance is serious in nature, or if the provider or member is not satisfied with the decision reached by the Services Review Panel, the case will be presented to the Peer Review Committee. All resolution letters inform members of their right to appeal the decision to the Peer Review Committee."*

The Department's review of the Plan's grievance resolution letters to enrollees found they fail to contain the enrollee's right to file an appeal with the Plan's Peer Review Committee (PRC) if they disagree with the initial grievance determination. During Department interviews, the Plan's Professional Services Coordinator stated that those grievance resolutions that are in favor of the enrollee do not require the appeal language. Nevertheless, the Plan's resolution letters must include the enrollee's right to file an appeal to the initial grievance determination as stated in the Plan's grievance policy and EOC.

Corrective Action 8: The Plan shall submit a Corrective Action Plan to ensure enrollees are informed of their right to file an appeal to the initial grievance determination. The Plan's CAP shall include a revised template grievance resolution letter that includes information on the Plan's appeal process.

Plan's Response and Compliance Efforts 8:

The Plan's response to the Preliminary Report January 13, 2003 states that the Plan's resolution letters have included notice to enrollees on the appeal process when the Plan modified or denied the initial grievance issue. The Plan did not realize that grievance resolution letters that resolved the issue in favor of the enrollee also require the appeal language. The Plan's Response includes a copy of the revised Grievance Process Policy and Procedures, which now requires all grievance response letters to contain information on the Plan's appeal process. The Plan's Response also includes a template resolution letter, which includes information on how the enrollee can appeal the initial grievance determination.

Department's Finding Concerning Plan's Compliance Effort 8:

Not Corrected. The Department found that the Plan's compliance efforts do not adequately address this deficiency by the time of the forty-five day response. Additional time is required to correct this deficiency. The Plan's Response fails to include evidence that the Plan's governing body or appropriate Plan committees have approved the revised grievance system policy and procedure. The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review. At the time of the Follow-up Review, the Plan shall demonstrate review and approval of the revised grievance system procedures.

Deficiency 9: The Plan's grievance letters and complaint form do not contain the required language pursuant to Section 1368.02(b). [Section 1368.02(b)]

Citation:
Section 1368.02(b) states that every health care service plan shall publish the department's toll-free telephone number, the California Relay Service's toll-free numbers for the hearing and speech impaired, the plan's telephone number, and the department internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number, and the department's internet address shall be displayed by the plan in these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free number (insert telephone number) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the department. The department's Internet website (insert website address) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at [plan's telephone number] and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that

has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law."

Department Findings: The Department's review of twenty-five (25) grievance files found three (3) grievance resolution letters and one (1) complaint form filled out by an enrollee contain the following language:

> *"The California Department of Corporations is responsible for regulating health care service plans. The department's Health Plan Division has a toll-free telephone number 800/400-0815 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (800/735-2929 (TTY) or 888/877-5378 (TTY)) to contact the department. The department's Internet website http://www.corp.ca.gov has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at 800/637-6453 and use the plan's grievance process before contacting the Health Plan Division. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 60 days, you may call the Health Plan Division for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law."*

The Department found the above language is not in compliance with Section 1368.02(b). The above language contains the incorrect Department name. Additionally, the Internet website address listed is the website for the Department of Corporations, not the Department of Managed Health Care. The Department's current website address is http://www.hmohelp.ca.gov. Finally, the Plan's three resolution letters and one complaint form instruct enrollees to contact the Department after participating in the Plan's grievance process for sixty days. Pursuant to Section 1368.02, enrollees may contact the Department for assistance after participating in the Plan's grievance process for thirty days.

Corrective Action 9: The Plan shall submit a Corrective Action Plan to ensure all grievance letters and complaint form contain the correct Department language pursuant to Section 1368.02(b).

Plan's Response and Compliance Efforts 9:

The Plan's response to the Preliminary Report dated January 13, 2003 states that the Plan's resolution letters have included the correct Department language with the exception of four letters/forms that contained the Department's previous language. The Plan's Response includes copies of the template grievance letter and complaint form to demonstrate that the seldom-used

template and complaint form with the out-of-date language have been revised to include the requested language.

The Plan's Response further states that the Department has adopted new language since the Plan's receipt of the Preliminary Report. All Plan letters are now in the process of being revised to include the newer format to meet the Department's most recent language, which is effective January 2003. The Plan's grievance template includes the following language:

> *"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at 800.637.6453 and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or grievance that has remained unresolved for more that 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (888.HMO.2219) and a TDD line (877.688.9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."*

Department's Finding Concerning Plan's Compliance Effort 9:

Corrected. The Department found that the Plan's compliance efforts adequately address this deficiency by the time of the forty-five day response.

Deficiency 10: The Plan's governing body and QA committees do not review tabulated grievance data on a quarterly basis. The Plan's QA Manager does not attend the Service Review Committee meetings on a consistent basis. [Rule 1300.68(b)(3)]

Citation:
Rule 1300.68(b)(3) states as to each complaint received in person or by telephone at a grievance location, a written record shall be made, including the date, identification of the individual recording the grievance, and disposition. A written record of tabulated grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to Section 1300.69, and by an officer of the plan or his designee, and the review procedure shall be documented, including documentation of the procedure or mechanism used in consideration of tabulating grievances periodically in relation to policy and procedure review.

Department Findings: The Plan's Grievance Process and System policy and procedure, states:

"The Service Review Coordinator maintains a log of all grievances. This log is reviewed quarterly by the responsible Manager to determine if there are any patterns or particular offices with which we are having problems. The Quality Assurance Management Committee also reviews call log reports as part of the Potential Quality Issues (PQI), to determine systemic problems or issues."

"Grievances with extended resolutions are further reported to the QAMC and the Board of Directors in quarterly reports. The QAMC or Board of Directors will immediately resolve any unresolved grievances that are presented to the Committee or the Board."

"The QA manager is present at the weekly Service Review meetings. All member grievances are discussed and action items given to appropriate staff, including the QA Manager. These action items may include a surprise office visit or a scheduled quality assurance audit."

The Department reviewed the Plan's governing body meeting minutes dated June 28, 2001; October 2, 2001; December 27, 2001; March 28, 2002; June 27, 2002; and September 26, 2002. The Department also reviewed QAMC meeting minutes dated November 19, 2001; January 30, 2002; April 15, 2002; and September 12, 2002. In addition, the Department reviewed the QA/Peer Review Committee minutes dated March 27, 2001; June 26, 2001; October 10, 2001; December 11, 2001; March 19, 2001; July 9, 2002; and October 1, 2002. Finally, the Department reviewed the weekly Service Review Committee minutes from January 2001 through September 2002.

The Department's review found no evidence of the Plan's governing body and QAMC reviewing tabulated grievance reports or call log reports at any of the above meetings. The Plan's QA/Peer Review Committee reviewed grievance information on March 27, 2001 and October 1, 2002; however, this review is limited to the total number of grievances received for the quarter and the percentage of grievances pending resolution or closed within the thirty-day requirement. The Department did not find evidence of the above Plan committees reviewing data on the number and types of grievances received on a quarterly basis.

The Department also found that the Plan's QA Manager only attended five (5) out of sixty (60) weekly Service Review Committee meetings from January 2001 through September 2002. During Department interviews, the Plan's QA Manager stated that she is not involved with the Service Review Committee. This statement contradicts the Plan's grievance system policy, which states that the Plan's QA Manager attends each Service Review Committee meeting.

Corrective Action 10: The Plan shall submit a Corrective Action Plan to ensure the Plan's governing body and appropriate QA committees review tabulated grievance data on a quarterly basis. The Plan's CAP shall include a template tabulated grievance form to include the number and type of grievances received by the Plan in the reporting quarter. The Plan's CAP shall also include a revised grievance system policy and procedure to clarify the QA Manager's role in grievance review and the Service Review Committee.

Plan's Response and Compliance Efforts 10:

The Plan's response to the Preliminary Report dated January 13, 2003, states that the Plan's QAMC reviews grievance data, but it is not documented in the monthly committee agenda or minutes. The QAC also reviewed the grievance data, but not every quarter. The Plan's governing body also heard presentations regarding the grievance data; however, the Board minutes are inconsistent in their documentation. This issue is being addressed by more formal presentations to committees and the Board on a quarterly basis, and the preparation of more detailed committee and Board minutes.

The Plan's Response includes a copy of the revised Service Issue Log, which contains the number and type of grievances received by the Plan in the reporting quarter. This required the Plan to also revise transaction codes used in Member Services and tracked within the Plan's system. The Plan's Response includes a list of definitions of the new transaction codes.

Finally, the Plan's Response states that the grievance policies were initially developed to include the QA Manager in all weekly Service Review meetings. Since that time, the responsibilities of staff positions have changed somewhat that require an update to the policy. The Plan's intent at this time is for the QA Manager to participate in the Service Review meeting when not in the field. The QA Manager will now be attending most of the weekly meetings. The Plan's Response includes a copy of the revised Grievance Process Policy and Procedures to better define the role and responsibility of the QA Manager in the Service Review Committee.

Department's Finding Concerning Plan's Compliance Effort 10:

Not Corrected. The Plan has not provided evidence that all corrective actions have been or are being implemented within the Plan's forty-five day response period. The Plan's proposed implementation of the corrective action will take longer than forty-five days to be accomplished. The Plan's Response does not include evidence that the revised grievance system policy and Member Services transaction codes have been approved by the governing body or appropriate Plan committee(s). For the remainder of the Plan's compliance efforts, the Plan requires additional time for full implementation of the corrective action plan.

The Department will evaluate full implementation of the Plan's corrective actions during the Follow-up Review. At the time of the Follow-up Review, the Plan shall demonstrate approval of the revised grievance system policy and Member Services transaction codes. The Plan shall also submit appropriate committee minutes to ensure tabulated grievance data is reviewed quarterly and the Plan's QA Manager attends the weekly Service Review Committee meetings on a routine basis.

UTILIZATION MANAGEMENT

Deficiency 11: The Plan's denial letters related to benefits coverage fail to include the specific provisions in the EOC that exclude coverage. [Section 1368(a)(4)]

Citation:
Section 1368(a)(4) states that every plan shall provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude the coverage.

Department Findings: The Plan's Denial Notice policy and procedure states that a Denial Notice is sent to providers and members whenever a claim or treatment plan is denied. The Plan's Denial Notice includes the patient's name, member's identification number, claim number, and the reason for the denial. The Plan also sends the provider and the enrollee an Explanation of Benefits for Specialty Referral Claims form for all approvals, denials, and modifications. The Explanation of Benefits for Specialty Referral Claims form includes the member's name, social security number, claim number, eligibility date, type of referral, the service(s) that are approved or denied, and the reason for the denial.

During Department interviews, the Plan's QA Dental Director stated that the Plan does not deny treatment authorization requests based on medical or clinical necessity. Rather, the Plan denies requested services based upon non-coverage issues only.

The Department found that the Plan's Denial Notice and Explanation of Benefits for Specialty Referral Claims forms do not include space for the Plan to insert the provision and page number in the Plan's EOC that exclude coverage. The Department reviewed a total of twenty-five (25) denials issued from January 2001 through September 2002. All twenty-five (25) denials are retrospective and services are denied due to non-covered benefits. The Department found no evidence of the Plan clearly disclosing provisions in the Plan's EOC, including the page number that exclude the requested coverage. Additionally, only one (1) denial file contains a copy of the Plan's Denial Notice and Explanation of Benefits for Specialty Referral Claims form. The remainder of the twenty-four (24) denial files fail to include the Denial Notice and only contain a copy of the Explanation of Benefits for Specialty Referral Claims form.

Corrective Action 11: The Plan shall submit a Corrective Action Plan to ensure the Plan clearly discloses the provision in the EOC that excludes coverage pursuant to Health and Safety Code Section 1368.02(a)(4). The Plan's CAP shall include copies of revised template Denial Notice and Explanation of Benefits for Specialty Referral Claims forms that provide space for the Plan to insert the provision and the page number from the EOC that excludes the requested service.

The Plan shall also submit a Corrective Action Plan to ensure the Plan follows its internal policy and procedure by sending Denial Notice letters to enrollees and providers whenever a claim or treatment plan is denied.

Plan's Response and Compliance Efforts 11:

The Plan's response to the Preliminary Report dated January 13, 2003, states that the Plan has revised its Denial Notice letters, attachments, and procedures to clearly disclose, in those cases that the denial is based on a determination that the proposed service is not covered, and the provision in the EOC that excludes coverage. Some cases are denied or not processed for reasons such as eligibility and incorrect or illegible information and do not have an EOC reference. The Plan's Explanation of Benefits for Specialty Referral Claims (EOB) form is formatted to receive claim system data only and cannot be redesigned at this time. In order to comply with the requirement, the Denial Notice has been revised to include the EOC provision that excludes the requested service and references which section in the EOC the provision can be found. The Plan's Response includes a copy of the revised Denial Notice. Each Denial Notice is customized to the particular claim. Referencing page numbers is not appropriate because the Limitations and Exclusions are located on various EOC pages, some of which are not numbered, depending on particular Plan literature. The EOB that accompanies the Denial Notice contains the Department's RFA language. The Plan's system tracks the date the claim is approved or denied and processed, which includes the mailing of the EOB and appropriate denial letter.

In addition, the Plan's Response states that the Plan previously used the EOB form to explain claim denials and used the Denial Notice primarily when denials are for medical/clinical reasons. This deficiency is now being addressed by including the Denial Notice (and EOC disclosure) with all denied treatment plans and claims. The Plan's Response includes a copy of the Denial Notice Policy and the Specialty Referral Policy and Procedures.

Department's Finding Concerning Plan's Compliance Effort 11:

Not Corrected. The Department found that the Plan's compliance efforts do not adequately address this deficiency by the time of the forty-five day response. The Plan's Response fails to include evidence that the Denial Notice and Specialty Referral policies and procedures have been reviewed and approved by appropriate Plan committees.

In addition, the Plan's Response states that referencing page numbers in the Denial Notice is inappropriate because the Limitations and Exclusions are located on various EOC pages depending on the particular Plan literature. However, Plan's revised template denial letter fails to clearly specify the provisions in the contract that exclude the coverage pursuant to H&S Code Section 1368(a)(4). The Plan's revised Denial Notice template states, *"Plan coverage does not include specialty benefits. See Exclusions and Limitations section of your Evidence of Coverage."* Simply instructing the enrollee to refer to the Exclusions and Limitations section of their EOC does not clearly inform the enrollee those specific provisions in their contract that exclude the coverage.

The Department finds the Plan's corrective action plan is insufficient to correct this Deficiency as requested and requires further Remedial Actions in this Final Report.

Remedial Action 11:

The Plan shall submit revised policies, procedures, and template denial letters to ensure denials based on coverage (i.e., non covered benefits) clearly specify the language or section of the EOC that limit or exclude coverage. This Remedial Action shall be submitted to the Department within thirty (30) days of receipt of this Final Report.

Appendix A

Department Survey Team

• Ed Foulk, R.N., M.B.A., Ed.D.	Staff Health Plan Analyst (Team Leader)
• Shelly Williams, M.H.A.	Associate Health Plan Analyst
• John D. Williams, DDS	DMHC Dental Consultant
• Crystal Lee	Graduate Student Assistant

Appendix B

Plan Staff Interviewed (Titles)

- Vice President, Health Services
- Quality Assurance Dental Director
- Quality Assurance Coordinator
- Manager of Dental Operations
- Service Review Coordinator (Grievance Coordinator)
- Director of Services (Group & Member Services)
- Member Services Supervisor

Appendix C

List of Acronyms

Acronym or Abbreviation	Definition
Act	Knox-Keene Health Care Service Plan Act of 1975, as amended.
Board or Governing Body	Board of Directors (BOD)
CAP	Corrective Action Plan
DHS	Dental Health Services or the "Plan"
Department	Department of Managed Health Care
EOC	Evidence of Coverage
HMO	Health Maintenance Organization
Ortho	Orthodontics or Orthodontist
Plan	Dental Health Services or DHS
PRC	Peer Review Committee
PPO	Preferred Provider Organization
QA	Quality Assurance
QAMC	Quality Assurance Management Committee
QAP	Quality Assurance Program
QAC	Quality Assurance Committee
RCT	Root Canal Treatment
UCR	Usual, Customary & Routine
UM	Utilization Management
UMC	Utilization Management Committee